

Multiple failings in care of older person in final months of life

Executive summary

1. Mr A was a resident at Mary Shapley Rest Home and Hospital (Mary Shapley).¹ Mr A's daughter, Ms B, complained to the Health and Disability Commissioner (HDC) about the standard of care Bupa provided to her father between 1 March and 15 April 2022 when his health declined. Mr A died in April 2022, and I offer my condolences to his family for their loss.
2. This investigation focuses on the management of Mr A's decreased food intake and weight loss, wound care, pain and falls management, end-of-life care, and communication with Mr A's family regarding his condition.
3. In relation to Mr A's nutritional and weight management issues, his wound care, the management of his pain and falls, and the lack of appropriate end-of-life care, I find Bupa in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code), which states that consumers have the right to have services provided with reasonable care and skill.

Changes made and recommendations

4. Bupa has implemented the following changes since these events:
 - Employed a new general manager with extensive experience managing rest homes.
 - Conducted a review of Mary Shapley's staffing ratios and improved the resident-to-staff ratios to ensure consistent care is provided. Staffing levels have significantly improved in the years since the COVID-19 pandemic, and processes are in place to support Mary Shapley to fill vacancies.
 - Implemented VCare, which is software for managing resident records, care planning, monitoring, and administrative and financial tasks. VCare allows Mary Shapley to access clinical data in real time to monitor quality and compliance. VCare also sends an alert to Mary Shapley staff when prompted by triggers such as resident weight loss. These alerts prompt staff to take appropriate action and follow up.
 - Implemented the Power BI Clinical Dashboard, which displays daily data from VCare on a range of clinical indicators. This allows for a transparent overview of each Bupa care home and the setting of key performance indicators for benchmarking purposes and ensures follow-up where care homes do not meet performance benchmarks.

¹ A subsidiary of Bupa Care Services New Zealand (NZ) Limited.

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- As part of the automation of clinical care assessments in VCare, Bupa reviewed existing pain assessment tools. The Abbey Pain Scale and the Iowa Pain Assessment tools were merged into one assessment tool. Staff are required to enter 'yes' or 'no' into Vcare in response to a question on whether the resident can verbalise their pain. Based on their response, the correct pain assessment tool is generated for completion. Bupa has stated that this system improves accurate selection of the appropriate pain assessment tool for each resident.
- Clinical audits are now completed by Bupa's quality partner instead of clinical managers to provide independent assurance. Audits include wound management, clinical assessment and care planning, nutrition and weight management, and falls management.
- The Falls Prevention and Management policy and the falls risk assessment and falls event templates have been updated in VCare.
- A clinical newsletter that includes information on falls, wound care, complaints, and weight management as well as other clinical issues is now shared monthly among Bupa care homes.
- Participated in research with the Health Quality & Safety Commission Te Tāhū Hauora (HQSC) on the Deterioration Early Warning System (DEWS), a system to help aged residential care facilities identify and respond to deterioration in residents. They are working with HQSC on ways to implement this within their facilities.
- Implemented a virtual nurse service that care homes can access for extra advice and support if required. This service is available 7pm–7am on weekdays and 7am–7pm on weekends.
- Appointed a national physiotherapist, whose role is to provide clinical leadership and expert advice to Bupa care home teams and to strengthen relationships with existing physiotherapy providers.
- Appointed a national dietitian whose role is to provide clinical leadership and expert advice to Bupa care home teams and to design a balanced and nutritious menu alongside Bupa's national chef. This menu will be available for residents at all Bupa care homes.
- With a view to improving communication and direct engagement with the care home, a meeting with a local general practitioner (GP) service resulted in a plan for one GP from the practice to support onsite visits for residents who were not mobile, whereas mobile residents were supported to visit a GP at the practice. In June 2026, Bupa advised that a different GP practice now provides services to Mary Shapley.
- Working in collaboration with Health New Zealand | Te Whatu Ora to ensure that the care and oversight of residents at Mary Shapley is safe and appropriate.

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- Piloting an app that supports communication with residents' families and visibility of care plans and interventions in several Bupa care homes. The app is planned to be released in all care homes in the second half of 2026.

5. I acknowledge and support these changes. In addition, I recommend that:

a) Bupa provide education to Mary Shapley care home staff on the following topics:

- Bupa's Weight Management policy. As part of this, the training should cover what steps are to be taken when a resident experiences unintentional weight loss and the threshold for intervention, the steps to be taken when a resident has a decline in food and fluid intake, and who staff can refer to for further support.
- Pain management in relation to wound care.
- Bupa's Falls Prevention and Management policy, including completing post-fall reviews.
- End-of-life care. This includes recognising when a resident may be at the end of their life, communication with the resident and their loved ones about end-of-life care during a resident's last days of life, and the responsibilities in Bupa's 'Supporting a Dying Resident and Their Family/Whānau' policy.

Bupa is to provide evidence that education on the above topics has occurred to HDC in the form of education materials and staff attendance records, including the percentage of staff that has attended training sessions. Training is to be completed, and the relevant evidence forwarded to HDC, within six months of the date of this report;

- b) three months after the completion of (a), Bupa undertakes an audit on compliance against the Weight Management policy, including whether food and fluid charts are being used appropriately;
- c) three months after the completion of (a), Bupa undertakes an audit on the compliance against Falls Prevention and Management policy, including whether post-fall reviews and falls risk assessments are being completed appropriately;
- d) three months after the completion of (a), Bupa undertakes an audit of compliance against the nursing responsibilities outlined in the 'Supporting a Dying Resident and Their Family/Whānau' policy.
- e) within nine months of the date of this report, Bupa undertakes an audit on the compliance against the Wound Management policy, including whether dressing changes are occurring regularly, non-healing wounds are appropriately escalated, and documentation is being completed appropriately;

A summary of the audit findings for (b) to (e) is to be provided to HDC, along with any corrective actions to be taken, within ten months of the date of this report.

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Background

Relevant medical history

6. Mr A, aged 84 at the time of the events, had been living at Mary Shapley since June 2021 and was receiving hospital-level care. He had multiple comorbidities, including severe osteoarthritis² in both hips, peripheral vascular disease,³ metastatic prostate cancer, and non-healing ulcers⁴ and recurrent cellulitis⁵ on both lower legs. Mr A's admission records also indicate that he had some cognitive impairment and could be confused at times. He required two people to assist with all activities of daily living. He could not mobilise independently and had a high risk of falls. On admission to Mary Shapley, Mr A was noted to require some prompting with eating and drinking.
7. In July 2021, Mr A had an Enduring Power of Attorney (EPOA) in favour of Ms B activated for his care and welfare.
8. On 15 April 2022, Mr A was transferred to the local public hospital after he became unwell. Sadly, he passed away later in April 2022.

Nutrition and weight management

9. Ms B raised concerns about Mr A's nutritional management, particularly that appropriate steps were not taken to manage Mr A's decreased appetite and food intake in March 2022. As discussed above, Mr A was noted to require some prompting with eating and support to eat healthily.
10. Bupa told HDC that Mr A had periods of eating well with support from staff but also other periods where he refused to eat and drink. In these instances, staff would offer him more time and space to eat, assist him with his meals, offer choices of food and drinks, and complete food and fluid balance charts. However, the Nursing Admission Assessment form did not document these nutritional concerns and instead recorded that Mr A was eating and drinking well. In contrast, the Care Summary recorded that he needed prompting with eating and drinking, but no other interventions were recorded.
11. A Mini Nutritional Assessment completed five months after Mr A moved into Mary Shapley classified him as 'malnourished'. There are no records of interventions to manage his malnourishment.
12. In addition, Mr A's clinical records show that he had been losing weight prior to March 2022. From November 2021 to March 2022, his weight decreased from 92.3kg to 71.8kg (more than 20% of his body weight).⁶ Despite Mr A's significant weight loss, there is no documented plan for managing his weight, no increase in the frequency of his weight being monitored, and no evidence of referral to a dietitian being considered.

² A condition that causes the affected joints to become painful and stiff.

³ A condition where the arteries in the lower legs become narrow because of a build-up of fatty deposits. This leads to poor blood circulation in the legs.

⁴ Sores that do not show significant improvement in four to six weeks and do not heal in eight weeks.

⁵ An infection of the skin and the deeper layers of the skin.

⁶ Between February and March 2022, Mr A's weight decreased from 76.3kg to 71.8kg (6% loss of body weight).

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13. Ms B said that, by March 2022, Mr A had stopped eating and that Mary Shapley staff did not do anything to manage this. Progress notes make frequent references to Mr A experiencing decreased appetite and food intake, as well as refusing meals from 1 March 2022 onwards. However, entries regarding the quantity of food and fluid intake were inconsistent over March and April 2022, and documentation around how the decreased food intake/appetite was managed, including whether it was escalated to a registered nurse (RN), is limited.
14. On 8 March 2022, Mr A's family raised concerns to Mary Shapley's unit coordinator about his decreased food and fluid intake. On 9 March 2022, the unit coordinator sent an ISBAR⁷ communication form to Mary Shapley's GP regarding Mr A's decreased appetite. The ISBAR notes Mr A's recent weight loss, refusal of meals and medication, and comments to his family that he does not like to eat and feels like he does not have long to live. The unit coordinator requested that the GP chart a nutritional supplement. Mr A and his family had agreed to this plan. Subsequently, Mr A was commenced on Diasip (a nutritional supplement).
15. There was a small delay in providing Diasip to Mr A, due to stock being unavailable at the local pharmacy. Medication records from 11 March to 15 April 2022 show Mr A regularly refused Diasip. He told nursing staff and his family that he did not like the taste. On several occasions, Mr A's medication records also state that his Diasip was 'missed' but do not provide a reason for this. There is no record of Mr A being charted or offered an alternative dietary supplement in place of Diasip.
16. Progress notes state that, on 21 March 2022, an RN informed the GP that Mr A was refusing Diasip and other medications. The GP said she would discuss a hospice referral (discussed in paragraph 46) for Mr A with Ms B because of his prolonged decreased appetite. Bupa stated in their response to HDC that Mary Shapley staff were expecting the GP to provide a plan to address Mr A's refusal of Diasip. This is not recorded in the progress notes, and the GP did not provide further advice on how to manage Mr A's food intake and weight loss.
17. When Mr A was transferred to the local public hospital on 15 April 2022 (discussed in paragraphs 52-55), both St John Ambulance staff who transferred Mr A and the emergency department (ED) doctor who assessed him noted Mr A's frail appearance. St John Ambulance staff noted that he had had little food intake for weeks. The ED doctor noted that Mr A appeared cachexic.⁸

Wound care

18. As noted in paragraph 6, Mr A had a history of non-healing ulcers on his lower legs. These non-healing wounds were complex and required ongoing management, including regular dressing changes and pain management. Mr A was also assessed as being at high risk of developing pressure injuries.⁹

⁷ ISBAR stands for Identify/Introduction, Situation, Background, Assessment and Recommendation/Request. The ISBAR tool is a structured communication tool used in healthcare settings.

⁸ Cachexia is a syndrome characterised by severe weight loss and muscle loss, usually related to a serious underlying condition such as advanced cancer.

⁹ Injuries to the skin and underlying tissues caused by prolonged pressure on the skin.

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19. Ms B expressed concern about the management of Mr A's wounds, including concerns about the frequency of dressing changes and flies and maggots being found on the wounds when dressings were not intact.
20. Mary Shapley regularly sought input from specialists, including clinical nurse specialists and wound care nurses, on how to manage Mr A's non-healing ulcers, including how to prevent maggots on his wounds (discussed further in paragraph 27).
21. Wound Initial Assessment and Plan forms were completed for Mr A's non-healing ulcers on the day of his admission to Mary Shapley. These documents noted the wound type, size and location, cause, risk factors for healing, pain levels, frequency of dressing changes, and the types of dressings to be used.
22. Wound Evaluation forms were used to capture information on the appearance and condition of the wounds, signs of infection, pain, the dressing plan, care of the surrounding skin, and when the next dressing was scheduled. Wound Evaluation forms and dressing changes appear to have been completed following the schedule in the wound care plan (every three to five days). However, there are times when dressing changes are documented more or less frequently than scheduled. Wound care plans were not always updated to reflect changes in the frequency of dressings, and the Wound Evaluation form does not include a reason for the change in frequency. Wound Evaluation forms were only completed until the end of February 2022. It is not clear why they stopped being used. However, dressing changes continued to be documented in the progress notes.
23. Progress notes show that Mr A sometimes refused to have his dressings changed because of pain or because staff wanted to change his dressings later in the day, when he preferred to have them changed earlier.
24. There appears to have been some uncertainty among Mary Shapley staff about how often dressings needed to be changed. Initially, wound care plans noted that dressings should be changed every three to five days, depending on the wound. Mr A's daughters understood from attending GP appointments with him that dressing changes needed to be done daily, and they emailed Mary Shapley in November 2021 to confirm this was being done. The unit coordinator apologised that the dressing had not been changed the day before and said she would speak to the GP to confirm how often dressing changes needed to be done. There is no record of this conversation occurring. Dressings continued to be changed and documented irregularly between November 2021 and February 2022, with periods where dressings were changed daily and others where they were changed every few days.
25. In February 2022, after Mr A was hospitalised for cellulitis and discharged back to Mary Shapley, the long-term care plan was updated to note that his left lower leg ulcer was to be reviewed daily and that wounds were to be covered at all times to prevent flies from accessing the wound. The dressing placement was to be reviewed and documented on each nursing shift. The requirement to change Mr A's dressings daily and check his leg during each shift was reiterated in the progress notes on 18 February 2022. Between 1 March and 15 April 2022, progress notes indicate that dressing changes were done most days but not daily.

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Progress notes sometimes refer to placement of dressings but do not show them being checked and documented during every shift.

26. Progress notes state that maggots were found on Mr A's leg wounds on multiple occasions. Between 1 March and 15 April 2022, maggots were found and removed on five occasions: 3, 18 and 20 March 2022, 3 and 8 April 2022. Bupa said that a fan was placed in Mr A's room on 10 March 2022 to keep the flies away from his wounds.
27. Bupa said that, after maggots were found on 18 March 2022, the wound was thoroughly cleaned, maggots removed, and the wound escalated to the clinical manager. The clinical manager emailed and called the wound care nurse to request clinical advice on how to better manage Mr A's wounds. The wound care nurse responded on 21 March 2022 advising that there were not many options for management of such complex wounds besides controlling exudate (pus), reducing the risk of infection, and managing discomfort. She suggested that the clinical manager contact the surgical services team promptly to request a follow-up review given the complexity of the wounds and concerns that maggots had been found.
28. Mary Shapley staff did not contact the surgical services team until 7 April 2022. Progress notes on this date state that they called the surgical services team regarding Mr A's leg ulcer and were advised to send a referral via the GP. An ISBAR form to the GP requesting Mr A be referred to surgical services was sent on 8 April 2022. As no further response from surgical services was provided to HDC, it is unclear whether the GP made a referral.
29. When maggots were found on Mr A's leg wound on 3 April 2022, progress notes record that the RN asked Mr A whether he wanted to go to the ED, but he declined.

Pain management

30. Mr A required ongoing pain management for his osteoarthritis, chronic leg ulcers, and cancer. Ms B is concerned about various aspects of Mr A's pain management.
31. No overarching pain management plan is documented for Mr A. However, pain is discussed in the long-term care plan that was created following his admission to Mary Shapley. The plan notes that Mr A experienced intermittent pain because of his leg ulcers and this was managed with paracetamol. After Mr A was discharged from hospital in February 2022 after the admission for cellulitis, the long-term care plan was updated to note that Mr A was constantly in pain and required pain medication to be administered (paracetamol, oxycodone, and OxyNorm) in a timely manner.
32. Regular pain assessments were completed from admission until 10 March 2022. These assessments included a pain intensity score, location and type of pain, when pain occurred, things that worsened the pain, and interventions and their effect.
33. Bupa stated that, from 7 March 2022 to 15 April 2022, regular documentation was suspended because of a COVID-19 outbreak at Mary Shapley and it is possible that pain assessments were temporarily stopped as part of this process.

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34. Mr A's family raised concerns with Mary Shapley about his pain medication and management, including the strength of pain medications he was prescribed and processes in place for escalating to the GP when pain management was not effective. Mr A told his family in October 2021 that he did not want to take paracetamol as he felt it was not effective. Mr A's family also requested that he stop oxycodone and OxyNorm, which he was prescribed after his discharge from hospital in February 2022, as he felt the sedative effect was too strong for him. Mr A was also noted to have experienced hallucinations and confusion when taking these medications. Regular oxycodone was stopped on 23 February 2022, and Mr A was reported to have told the unit coordinator he felt more alert and 'more himself' after stopping oxycodone. Medicine administration records show that Mr A was still given oxycodone liquid from 7 to 14 April 2022 for pain relief or before dressing changes. The records do not state why oxycodone was given over this period when it had been stopped on 23 February.
35. Ms B also raised concerns that, on some occasions, care staff did not appropriately manage Mr A's pain when dressing his wounds by providing pain medication and allowing time for it to take effect before removing his dressings, as they were instructed to do, and by moistening or soaking dressings to reduce pain before removal. Mr A had told Ms B this had happened on at least one occasion, and another daughter had also emailed Mary Shapley to raise these concerns. The unit coordinator apologised for Mr A's painful experience and said she would speak with staff caring for him about this. Progress notes and medication records do indicate that pain medication was often given before dressing changes, with good effect. Wound Evaluation forms also document dressings regularly being soaked or washed with sterile saline or Prontosan, although this was not done at every dressing change and the form does not specify the reasons this was not always done.
36. Mr A complained of severe pain in his legs and hips when he was transferred to the local public hospital on 15 April 2022. This was documented by St John Ambulance staff and the ED doctor who assessed Mr A in hospital.

Falls management

37. As discussed, Mr A was assessed as being a high falls risk on admission. Ms B told HDC that Mr A had experienced many falls and expressed concern around several aspects of the falls management at Mary Shapley.
38. A falls risk assessment was completed on the day Mr A was admitted to Mary Shapley, and he was assessed as being a 'medium' falls risk. In contrast, Mr A's long-term care plan recorded that he was a high falls risk. The falls risk assessment was not updated when Mr A's health declined in March 2022, with decreased appetite and changes to his medication (stopping oxycodone and OxyNorm). In addition, the long-term care plan does not appear to have been reviewed after the fall events in March and April 2022 (discussed in paragraph 42).
39. Mr A's family stated that he would often be kept waiting when he needed to use the bathroom and would try to take himself, potentially contributing to falls. In addition, Mr A's family said that, although two people were meant to assist him, Ms B observed that this did not happen on several occasions.

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40. The long-term care plan noted that Mr A was to be monitored by staff on an hourly basis because of his high falls risk. Progress notes do not record Mr A being checked hourly but do mention staff responding to Mr A pressing the call bell. The time taken for staff to respond to the call bell is not known.
41. In addition to the hourly monitoring, Mr A attended physiotherapy sessions twice a week to improve his mobility. However, physiotherapy progress notes end on 25 November 2021. Email correspondence between Mary Shapley and Mr A's family in October 2021 states that the physiotherapist had been unable to visit at times because of COVID-19 restrictions. Other than the outbreak from 7 March to 15 April 2022, it is not known what other outbreaks occurred at Mary Shapley and when. Mr A's family are concerned that his physiotherapy sessions were not delivered according to his care plan.
42. Progress notes document that Mr A had three unwitnessed falls on 31 March, 6 April, and 14 April 2022. The notes indicate that the fall on 31 March occurred when Mr A tried to transfer himself from the bed to his wheelchair, but there are no details as to how the other two falls occurred. Incident reports, post-fall assessments, skin assessments, pain assessments, and neurological observations were completed after all three falls. An ISBAR form was sent to the GP requesting an in-person post-fall review for Mr A after his fall on 6 April 2022. However, a GP review was not requested after the falls on 31 March and 14 April 2022.
43. Post-fall management checklists included in the Post-Fall Assessment form were completed for other falls Mr A had at Mary Shapley but not for any of the three unwitnessed falls that occurred in March and April 2022.
44. When Mr A had a fall in July 2021, the post-fall management checklist was completed and resulted in interventions to prevent future falls. These interventions included putting a sensor mat and a crash mat¹⁰ in Mr A's room, staff checking him half-hourly, and having the GP review Mr A and make changes to his medications to try and reduce his level of confusion.

Referral to hospice and end-of-life care

45. Ms B raised concerns that, although Mary Shapley advised her that Mr A would be referred to hospice, he had not been seen by hospice staff or received end-of-life care before his admission to hospital on 15 April 2022. Clinical records do not show that an end-of-life care plan was initiated for Mr A.
46. On 31 March 2022, the GP assessed Mr A and referred him to the local hospice. Her consultation notes state that the referral was made as he was not eating and drinking much. The notes also state that she contacted Ms B and 'explained everything', but no details of the conversation are recorded.

¹⁰ Sensor mats trigger a signal when a resident steps on them to alert care staff to their movements. A crash mat is a soft padded mat that minimises the impact of injury from a fall.

47. A retrospective progress note made on 8 April 2022 stated that, on 7 April 2022, the unit coordinator received a call from hospice asking why Mr A had been referred to their service. The unit coordinator told hospice that Mary Shapley needed input regarding Mr A's non-healing leg ulcers and constant pain and his recent refusal of medication. She was told that hospice could not help with these issues but that Mary Shapley could contact them at any time if they needed hospice advice.
48. There is no documentation to indicate that this conversation was communicated to the GP or Ms B. When the GP spoke to Ms B after Mr A's death, her notes state that Ms B asked her why hospice had not seen Mr A given the referral, and the GP said she did not know.
49. Although Mary Shapley staff were aware that a GP referral to hospice had been made, a palliative care plan was not completed. A Resuscitation (CPR) Treatment Plan completed with Mr A in June 2021 stated that he was for resuscitation. Sections on the form relating to advance care plans were not completed, including whether Mr A wanted further information on advance care planning. No other end-of-life care preferences appear to have been documented for Mr A. In their response to HDC, Bupa stated that they expected the GP to lead conversations about end-of-life care with residents and their families.
50. The GP also did not discuss end-of-life care preferences with Mr A and his family. In her response to HDC, the GP said she did not get a chance to talk about end-of-life care with Mr A as Mary Shapley had a COVID-19 outbreak shortly after the referral to hospice was made. Mr A also tested positive for COVID-19 on 11 April 2022, and the decline in his health was 'pretty fast and a bit unexpected'.
51. On 1 April 2022, Ms B emailed Mary Shapley asking to visit Mr A despite the facility being closed to visitors because of the COVID-19 outbreak. She noted Mr A's hospice referral as one of the main reasons she was asking to be able to visit him. The care home manager declined Ms B's request to visit Mr A, as only end-of-life compassionate visits were permitted.

Transfer from Mary Shapley to the local public hospital – 15 April 2022

52. At 2.30pm on 15 April 2022, an RN noted that Mr A was 'really weak and tired' with a low heart rate of 44 beats per minute, low blood pressure of 100/70mmHg, high respiratory rate of 24 breaths per minute, and low oxygen saturation levels of 78%.¹¹ Progress notes state that he was short of breath but refused oxygen. The notes also state that he was not eating and drinking properly. The RN contacted Ms B to inform her of Mr A's condition. Ms B arrived at Mary Shapley shortly afterward and requested Mr A be transferred to hospital.
53. An ambulance was called at 3.23pm. On arrival at 3.40pm, St John Ambulance staff found Mr A in poor condition and experiencing a lot of discomfort. They noted he complained of severe pain, had unhealed ulcers on both lower legs, increased respiratory rate, and had had little food intake for weeks. They also noted that he appeared to be a palliative care

¹¹ A normal resting heart rate is 60–100 beats per minute. For most people, the ideal blood pressure is 120/80mmHg; 140/90mmHg or higher is considered high and 90/60mmHg or lower is considered low. Normal respiratory rates for an adult at rest are 12–16 breaths a minute. For most people, a normal blood oxygen level is 95–100%; anything <95% is considered low.

patient, but Mary Shapley staff informed them that he had not been assessed by the hospice service.

54. Mr A was transferred to the local public hospital and admitted for pain management and palliative care.
55. Mr A passed away in April 2022 in the local public hospital. His cause of death was listed as metastatic prostate cancer. Lower leg ulcers secondary to significant peripheral vascular disease were also noted as significant conditions contributing to Mr A's death.

COVID-19 outbreak

56. As discussed, there was a COVID-19 outbreak at Mary Shapley between 7 March and 15 April 2022, and Bupa advised that this had a significant impact on staffing. Over this period, progress notes only documented significant changes to a resident's health, including the results of any particular interventions. A Resident Daily Care Record was used instead, which included a checklist for staff that covered various aspects of a resident's care and wellbeing, including fluid and nutritional monitoring, toileting, whether there were any changes in the resident's health or behaviour, and whether these concerns had been escalated. However, this checklist was not completed every day and was often incomplete. It also did not include a section relating to wound care.
57. Bupa also said that a short-term care plan template was available over this period for teams to personalise and implement, which allowed for minimum expectations in relation to care provision to maximise assessment and monitoring of residents' conditions. However, there is no evidence that these templates were used to monitor Mr A's wounds, nutrition, weight, or falls prevention.

Responses to provisional opinion

58. Ms B was given an opportunity to comment on the 'background' section of the provisional opinion, and her comments have been incorporated into the report where relevant.
59. In her response, Ms B emphasised the profound impact that the events detailed in this report have had on her and Mr A's family. They continue to carry the memories of Mr A's pain and deterioration while at Mary Shapley and his condition on 15 April 2022. They feel that Mary Shapley let Mr A down and failed to adequately care for him.
60. Ms B was particularly concerned that oxycodone was given to Mr A without her knowledge in April 2022, during the last week of his life, after it had been stopped in February 2022 because of its effect on Mr A's alertness and cognition.
61. Bupa was given an opportunity to comment on the provisional opinion, and their comments have been incorporated into the report where relevant.
62. In their response, Bupa expressed their sincere apologies for Mr A's experience at Mary Shapley and acknowledged the distress caused to his family by this experience.

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63. Bupa also provided a written apology to be forwarded to Mr A's family by HDC, as this was a recommendation included in the provisional decision.

Analysis

Bupa – breach

64. As a healthcare provider, Bupa is responsible for providing services in accordance with the Code. In deciding that Bupa has breached Right 4(1) of the Code, which states that every consumer has the right to have services provided with reasonable care and skill, I have relied on advice from in-house aged care advisor, Ms Hilda Johnson-Bogaerts (see **Appendix A**).

Nutrition and weight management

65. There is concern as to whether staff at Mary Shapley appropriately identified and managed Mr A's decreased appetite and significant weight loss.
66. On admission, Mr A was identified as needing support with his nutritional intake; however, Mary Shapley's GP said it was not uncommon for Mr A to go through periods of refusing food and drink depending on his mood. The GP advised that his appetite would often improve within a few days. This can be seen in the nutritional records between November 2021 and April 2022, where Mr A is noted to refuse at least one meal on most days. A Mini Nutritional Assessment identified that Mr A was malnourished five months after his admission. In the months leading up to Mr A's death, records show that his decreased appetite was not improving and he continued to lose a significant amount of weight.
67. Progress notes make frequent reference to Mr A experiencing decreased appetite and food intake and refusing meals, but recording of food and fluid intake over March and April 2022 is inconsistent.
68. Standard 3.2.5 of the Ngā Paerewa Health and Disability Services Standard (NZS 8134:2021) stipulates that providers are responsible for ongoing assessments when there are changes in a consumer's health.
69. Ms Johnson-Bogaerts advised that, because of Mr A's significantly decreased food intake, a comprehensive review of potential causes should have been undertaken. This could have included reviewing oral health, medications, psychosocial factors such as loneliness, and other medical issues. However, there is no evidence of such a review. In my opinion, this was because Mary Shapley staff did not appear to recognise the significance of Mr A's malnourishment. Ms Johnson-Bogaerts also noted that his long-term care plan was not updated to reflect the changes to his eating and drinking that were recorded in the progress notes throughout March and April 2022. I agree with Ms Johnson-Bogaerts's advice.
70. Bupa's Weight Management policy (dated 29 June 2020) states that weight loss will be monitored more closely when it is unexplained or involuntary or exceeds 5% of body weight in a month, 7.5% in three months, or 10% in six months. As outlined above, Mr A lost over 20% of his body weight over the five months from November 2021 to March 2022 and 6% of his body weight between February 2022 and March 2022.

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71. The Weight Management policy sets out that, when unintentional weight loss is detected, an RN will:
- complete a full nursing assessment, which involves a review of vital signs, elimination patterns,¹² reports of pain etc;
 - commence a specific short-term care plan with person-centred strategies to support oral intake;
 - inform the GP and request a review of the resident;
 - commence monitoring of all food and fluid intake;
 - increase frequency of weights;
 - report on the clinical handover tool;
 - refer to the clinical manager for discussion at the next clinical review meeting;
 - discuss the offering of more frequent high-calorie and high-protein snacks and drinks between main meals with the kitchen manager;
 - ensure that oral intake record, weight chart and short-term care plan are reviewed at the clinical meetings;
 - discuss with a GP and refer to a dietitian if weight has not stabilised in two weeks.
72. There are no records of these Weight Management policy steps being taken when Mr A began losing weight unintentionally. Although concerns were raised about his decreased appetite with the GP in March 2022 and a nutritional supplement was charted, his weight loss began three months earlier in November 2021. In addition, the charting of the nutritional supplement was prompted by Mr A's family contacting Mary Shapley to raise their concerns about his decreased appetite and requesting that he be given a supplement. I am concerned that Mary Shapley staff did not follow up with the GP after the phone call with her on 21 March 2022 where they advised that Mr A was refusing Diasip. Although the GP said she would refer Mr A to hospice, he still needed adequate nutrition while awaiting hospice input.
73. Ms Johnson-Bogaerts advised that the nursing care, planning and oversight of Mr A's nutritional management represented a moderate departure from accepted practice. I accept this advice. I am critical that nursing staff at Mary Shapley failed to take the steps outlined in the Weight Management policy when Mr A experienced significant unintentional weight loss over a period of several months. Although it is possible that his weight loss and decreased appetite occurred as he was coming to the end of his life, the absence of any

¹² Aging affects elimination patterns by slowing gastrointestinal motility, reducing bladder capacity, and weakening pelvic floor muscles, increasing the risk of constipation, urinary frequency, and incontinence.

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further assessments or referral to a dietitian meant there was a lack of opportunity to intervene earlier and better support Mr A and his family to manage this.

Wound management

Frequency of dressing changes

74. There are concerns around the management of Mr A's complex and chronic unhealed leg ulcers, particularly in relation to pain management and changing dressings regularly to prevent maggots in the wounds.
75. Wound evaluation forms were initially completed somewhat regularly for Mr A's chronic leg wounds. These forms allowed the condition of the wound, pain, and dressings to be monitored. However, these forms were not completed in March and April 2022, making it difficult to determine the quality of wound care Mr A was provided in the last weeks of his life. Although progress notes documented dressing changes and dressing placements on some occasions, they do not provide the same level of detail on how Mr A's wounds and pain were managed.
76. There appears to have been a lack of clarity among nursing staff about how often Mr A's dressing changes needed to be done, and this lack of clarity, combined with Mr A's refusal at times to have his dressings changed, meant that dressing changes may not have always been done at an appropriate frequency.
77. The presence of maggots in Mr A's wounds on several occasions in March and April 2022 suggests that dressing changes were not occurring regularly enough or dressings were not always intact to prevent flies penetrating the wound. The updated long-term care plan instructed nursing staff to review Mr A's dressings daily and to check dressing placement during each shift. These instructions were also recorded in the progress notes on 18 February 2022 but do not appear to have been followed in March and April 2022 as dressing changes do not appear to have been recorded daily and dressing placements were not recorded during each shift.

Management of wound-related pain

78. Ms Johnson-Bogaerts's advice is critical of the limited documentation regarding pain management and lack of a pain management plan being developed, particularly given Mr A's chronic leg ulcers and osteoarthritis. Bupa's Wound Management policy (dated 24 August 2022) notes that pain will be assessed and recorded on the Wound Evaluation form at each dressing change. Although this was being done initially, both Wound Evaluation forms and pain assessments stopped being completed in March and April 2022. As previously noted, there was no overarching pain management plan for Mr A.
79. Although progress notes and medication use reports show that pain medication was often given with good effect before dressing changes and that dressings were soaked to aid removal, if this was not routinely done, as Mr A reported to his family, this may have contributed to his reluctance to have his dressings changed on some occasions.

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Referral to surgical services in April 2022

80. I acknowledge that Mary Shapley staff regularly sought input from specialists to help them manage Mr A's wounds and promote healing. However, it is concerning that there was a two-week delay in contacting the surgical services team for support when the wound care nurse had advised the clinical manager to do this promptly because of the presence of maggots in the wound. It is not clear from the documents provided why this delay occurred, but maggots were found twice more in Mr A's wounds before the GP was contacted to refer Mr A to surgical services. If input had been sought earlier, Mary Shapley staff may have been able to action any advice and prevent further instances of maggots in the wounds.

Summary of wound management

81. Although Mr A's chronic leg ulcers were acknowledged to be complex and difficult to manage, I am critical of Mary Shapley's management of his wounds. This includes the lack of clarity around how often dressing changes needed to be done, dressing changes not always being done as frequently as required, failure to document the placement of dressings as outlined in the long-term care plan and not ensuring that dressings were intact at all times to prevent flies and maggots in the wounds. Monitoring and management of Mr A's pain in March and April 2022 also appears to have been suboptimal as pain scores and assessments were not being used regularly over this period. I accept Ms Johnson-Bogaerts's advice that the absence of a comprehensive pain management plan, given Mr A's chronic wounds, represents a moderate deviation from accepted practice.

Falls management

82. Bupa's Falls Prevention and Management policy (dated 24 November 2021) states that all new residents will have a falls risk assessment done by a nurse on the day they are admitted to the facility. This was done for Mr A in June 2021. However, as previously noted, there were inconsistencies in Mr A's documented level of falls risk, with the Falls Risk Assessment stating he was at 'medium' risk of falls and the long-term care plan saying he was at 'high' risk.
83. Following the completion of the falls risk assessment, several interventions were included in Mr A's long-term care plan to manage this risk. These interventions included having staff monitor Mr A on an hourly basis, two people assisting Mr A with transfers, and instructions for staff to answer his call bell in a timely manner. When Mr A fell in July 2021, other interventions were put in place, including a sensor mat and a crash mat being put by Mr A's bed, half-hourly checks on Mr A, and a review by the GP, who made changes to Mr A's medication to help reduce his confusion.
84. The Falls Prevention and Management policy states that the falls risk assessment will be reviewed every six months or more frequently if there is a decline or change in the resident's health, where there have been more than two falls in 24 hours, or upon return from any acute hospitalisation. As previously noted, the Falls Risk Assessment and long-term care plan were not updated when Mr A's health changed in March 2022 and his food intake decreased. The long-term care plan was also not updated regarding falls when Mr A returned from hospital on 15 February 2022 and was prescribed oxycodone.

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85. As noted above, Mr A had several unwitnessed falls in March and April 2022, some of which resulted in injuries, including skin tears and bruising.
86. Post-fall monitoring of Mr A appears to have been acceptable. However, several steps in Bupa's Falls Prevention and Management policy do not appear to have been followed. This includes contacting the GP using the ISBAR tool to tell them about the fall and arranging a post-fall review if required, which was not done consistently for all falls.
87. Ms Johnson-Bogaerts noted in her clinical advice that sections in the long-term care plan were not updated when there were changes in Mr A's health. She also noted that the falls prevention plan was limited, did not include all interventions in place to reduce Mr A's falls risk and did not appear to have been reviewed following Mr A's unwitnessed falls in March and April 2022. She considered this to have been a moderate departure from accepted practice.
88. I accept Ms Johnson-Bogaerts's advice. Although some planning was done to manage Mr A's high risk of falls, including monitoring him regularly and using a hoist to transfer him, the plan is not detailed, and it is unclear whether checks were occurring regularly. Falls prevention plans were not updated when Mr A's health changed and additional factors may have increased his falls risk, such as decreased food intake and medication changes. Post-fall reviews, which may have identified what caused Mr A's falls and how the risk could be reduced in future, were also not completed for falls in March and April 2022.

End-of-life care

89. As discussed, both St John Ambulance staff and the ED doctor noted Mr A as being at the end of his life. From my own review of the clinical records, I am also of the view that Mr A was frail and reaching the end of his life. However, there appears to have been a lack of clarity among Mary Shapley staff as to whether Mr A was nearing the end of his life and the support and care he required.
90. Ms Johnson-Bogaerts advised that there was a lack of discussion with Mr A's family regarding the 'ceiling of care' and the development of an advance care plan, which was a moderate to significant departure from accepted practice. In light of Mr A's significant comorbidities, including metastatic prostate cancer, and his advanced age, I also agree that this was necessary. This discussion would have provided an opportunity to discuss Mr A's condition and may have better prepared Mr A's family for the deterioration in his health before his transfer to hospital on 15 April 2022.
91. On 31 March 2022, the GP referred Mr A to hospice services because of his decreased food intake. When a staff member from hospice contacted Mary Shapley to ask why Mr A had been referred to their service, the unit coordinator said that help was required to manage Mr A's ongoing pain and non-healing leg ulcers. Ms Johnson-Bogaerts advised that hospice services for people in aged care facilities may include pain and symptom management as well as training and support to nursing staff and families. Ms Johnson-Bogaerts advised that, if Mary Shapley staff required advice on managing Mr A's pain and leg wounds, a hospice was not the right service to provide this support. She queried whether there may have been a miscommunication between the GP and nursing staff regarding why Mr A had been

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referred to hospice. The response from the unit coordinator resulted in hospice advising that they could not support Mary Shapley and Mr A with their concerns, and the referral was not accepted. The unit coordinator did not tell the GP or Mr A's family about this. This meant there was no opportunity for the GP to follow up on the referral and clarify why Mr A required hospice services and ensure he received the support he needed.

92. The failure of Mary Shapley staff to recognise that Mr A may be in his last weeks of life meant that no end-of-life care planning was undertaken and that Ms B's request for permission to visit Mr A during COVID-19 lockdowns was denied even though the care home manager who denied the request stated in her email that 'end-of-life compassionate' visits were permitted. Subsequently, Mr A only saw his family when his health deteriorated, and he was transferred to hospital at his family's request on 15 April 2022 before passing away. This caused significant distress for his family and meant that any wishes Mr A may have had around end of life were not able to be recorded and put in place.
93. In their response to HDC, Bupa acknowledged that there were instances where communication with Mr A and his family was not in line with Bupa's expectations.
94. Bupa also stated that conversations on the 'ceiling of care' and end-of-life care would typically be led by the facility's GP. At the time of the events, Bupa advised that Mary Shapley was facing significant challenges engaging GP services, which meant the GP was not available to facilitate this discussion.
95. I am critical that Mary Shapley staff did not provide more information to Mr A and his family on his condition, the hospice referral, and advance care planning.

Summary

96. Mr A was a particularly vulnerable resident with multiple comorbidities, including cognitive impairment. His family were very involved in caring and advocating for him and trusted Bupa and Mary Shapley to provide him with comprehensive care that supported him to maintain his quality of life. I acknowledge the distress caused to Mr A's family by the failings in his care, particularly their shock at his deterioration in the last weeks of his life, during which they were unable to see him.
97. In their response to HDC, Bupa noted the impact of COVID-19 outbreaks on residents and staffing levels. Bupa stated that, despite staffing pressures during the pandemic, they continued to comply with the Aged Residential Care contract¹³ and tried their best to continue to provide services. I acknowledge the challenges that COVID-19 outbreaks and restrictions placed on aged care facilities such as Mary Shapley throughout the pandemic and the impact this may have had on the care Mr A received in March and April 2022 as well as on the ability of staff to document his care. However, the pandemic did not negate Bupa's responsibility for ensuring its residents were safe. Bupa was still required to provide a basic standard of care to Mr A and as outlined above, there were several instances where this was not the case.

¹³ A contract with New Zealand | Te Whatu Ora to provide aged residential care services.

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Conclusion

98. For the reasons outlined above, I find that Bupa breached Right 4(1) of the Code by failing to provide services with reasonable care and skill to Mr A in relation to nutrition and weight management, wound care, pain management, falls management, and end-of-life care.

Distribution

99. A copy of this report with details identifying the parties removed, except Bupa Care Services NZ Limited, Mary Shapley Rest Home and Hospital, and the clinical advisor, will be sent to HealthCERT at the Ministry of Health and Health New Zealand | Te Whatu Ora – Hauora a Toi Bay of Plenty and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Rose Wall

Deputy Health and Disability Commissioner

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Appendix A: In-house clinical advice to the Commissioner

The following in-house advice was obtained from Nurse Advisor (Aged Care), Ms Hilda Johnson-Bogaerts.

Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by Bupa Mary Shapley Home. In preparing the advice on this case, to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

Specifically, I am asked to review the clinical documentation on file and advise whether:

- i. nursing care and oversight relating to falls management, wound care management, pain management, and nutritional management was in line with accepted practice
- ii. in the circumstances, the cessation of physiotherapy was reasonable
- iii. in the circumstances, the delay for hospice input was reasonable
- iv. the communication with the family relating to the health decline was in line with accepted practice.

Review of clinical records

[Mr A] was a resident of Mary Shapley Care home since 17 June 2021 receiving hospital level of care. His medical history included bilateral hip osteoarthritis, peripheral vascular disease with non-healing ulcers on his left lower leg, recurrent cellulitis of lower limbs, diabetes, prostate cancer, previous cerebral vascular accident, a history of falls, and general frailty. He needed full assistance with activities of daily living and needed two carers to assist with transferring using a sling hoist; he would mobilise using a wheelchair. [Mr A] was independent with eating and drinking but needed encouragement and supervision because of low appetite. [Mr A] was reported to be very sensitive and fiercely independent, making his own decisions, and experiencing significant cognitive decline. He had an EPOA in place for welfare. His family was very supportive, visiting most days except during lockdown due to COVID-19.

During March and April 2022, [Mr A] experienced a significant decline in health, he had unwitnessed falls and tested positive for COVID-19 on 11 April 2022. On 14 April 2022, [Mr A] had another unwitnessed fall. When, on 15 April 2022, staff identified deterioration in his neurological status and oxygen saturation, it was decided to transfer him to hospital where, unfortunately, he passed away.

The provider explains that, between 7 March 2022 and 15 April 2022, the care home had "care consideration" processes in place as part of their crisis management. At the time, the care home was experiencing both significant staffing shortages and significant increased workload due to a high number of staff away from the workplace while testing positive for COVID-19, and due to a good number of residents with COVID. During that time, there was a mandate to delay non-essential services, and family could not visit their loved ones in the care home unless for compassionate reasons during the last days of life.

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Clinical advice

- i. **Whether nursing care and oversight relating to falls management, wound care management, pain management, and nutritional management was in line with accepted practice.**

[Mr A] had a long-term care plan in place that was reviewed and signed 5 July 2021 by the RN and signed off by his EPOA. Further updates to the care plan were included as his care needs changed. For example, after his discharge from [the local public hospital], there is a reference to an updated wound care plan and pain management relating to his “non-healing ulcers”.

The care plan includes that for “any significant deterioration in condition [of the wound] please contact [Ms B] and consider transfer to [the local public hospital] based on clinical reasoning out of hours”. Short-term care plans were in place for episodes when [Mr A] experienced cellulitis and other reversible health issues.

Reviewing the care plans and the progress notes relating to changes in [Mr A]’s care needs during March and April 2022, I note that the care plan relating to wound management of his leg ulcers had limited references to managing wound-related pain. I am concerned that I did not find a separate Pain Management Plan as could be expected for a resident with ongoing osteoarthritis pain and with significant and complex leg ulcers. Such a care plan would focus on quality of life by preventing break-through pain and include both a pharmacological approach as well as non-pharmacological methods, safety considerations, the need and frequency for proactive pain monitoring as well as caregiver and resident/EPOA education on potential side effects and when to escalate to the GP.

I also note that the long-term care plan did not reflect the changes in eating and drinking noted in the progress notes in March and April. Because of the significant decreased food intake, a comprehensive assessment on a potential cause was indicated, including review of oral health, medication review, a review of psychosocial factors such as loneliness and a medical evaluation. I note that the GP prescribed nutritional supplements; however, [Mr A] was noted to not like these and often refused.

I also note the long-term care plan relating to mobility was not updated when [Mr A] was assessed as needing transfer with full hoist rather than with the standing hoist. The care plan relating to falls prevention is limited and doesn’t seem to have been reviewed following the number of unwitnessed falls he suffered.

In conclusion, I consider the nursing care planning and oversight relating to falls prevention, pain management and nutritional management to have been a moderate deviation from accepted practice.

- ii. **Whether, in the circumstances, the cessation of physiotherapy was reasonable.**

The physiotherapy assessment completed 22 June 2021 includes that [Mr A] showed contractures of the right and left knee. Physiotherapy notes include recommendations for exercises [Mr A] could do such as knee stretches and foot pumping. The last entry relates to

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25 November 2021. It is not clear from the notes if, when and why physiotherapy was stopped. The provider response does not refer specifically to physiotherapy.

Considering the COVID-19 restrictions, which included cessation of non-essential therapies, this would have included cessation of physiotherapy.

iii. **Whether, in the circumstances, the delay for hospice input was reasonable.**

Most people are referred to hospice when their illness is no longer curable, when their illness has entered a terminal phase. Referrals are made through a health care provider, usually the GP. Services provided to consumers in residential care often include pain and symptom control but could also involve training and support to nurses and families. I note that [Mr A]'s care plan includes that he was for active treatment if he was to deteriorate. His medical problem list includes frailty; however I did not find in the notes reference to a discussion on the ceiling of care with him or his EPOA.

It is not clear from the notes what was included in the referral from the GP to the Hospice service. The progress notes of 8 April 2022 include a note that the hospice contacted the nurse asking why [Mr A] was referred to the hospice service. The notes of the unit coordinator include that it related to "the non-healing leg ulcer and that he is in constant pain". The hospice service then replied that "this is nothing much they can do about that ...". Reviewing the notes, I am concerned that, if the nurses needed input into pain management relating to leg ulcers, indeed the hospice service is not the right service for such support. There may have been miscommunication between the GP and the nurse?

iv. **Whether the communication with the family relating to the health decline was in line with accepted practice.**

The clinical documentation includes brief notes of communication with the EPOA/family about health events such as falls, skin tears, etc. The notes do not include the full content of, or any reaction from the family to, the communication. The provider response includes that they are unable to provide specific comments on the communication between the EPOA and the Care Home Manager regarding [Mr A]'s condition as she passed away. The provider acknowledges, however, in their response that there were instances where communication to [Mr A]'s family were not in line with Bupa's expectations, especially when the COVID-19 limitations were in place.

In addition to communication about individual health issues and events, it appears that there had not been conversations with [Mr A] and his EPOA about the ceiling of care and the development of an advance treatment plan. At such conversations, information is shared regarding the stage of frailty, long-term conditions and reasons for current medication. It appears that the ongoing deterioration and increased frailty of [Mr A] was a surprise to his EPOA.

In the situation that such a conversation was not initiated with the family, this would be seen by my peers as a moderate to significant deviation from accepted practice.

Hilda Johnson-Bogaerts, BNurs RN MHSc PGDipBus

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Nurse Advisor (Aged Care)

Health and Disability Commission

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